Sample Letter of Medical Necessity

Must be on the physician/providers letterhead

Please use the following guidelines when submitting a letter of medical necessity:

- The diagnosis must be specific. For example, a diagnosis of "fatigue, bone pain or weakness" is not specific – a diagnosis of "Osteoporosis" is specific.
- The recommended treatment must be named and described in detail by a licensed health care provider. A recommended treatment described, as "quitting smoking, healthier diet and regular or daily exercise recommended" does not provide enough information. Your provider must specifically name and describe the recommended treatment. An acceptable description of treatment would be "I recommend 800 IU of Vitamin D and 1200 mg of Calcium supplements each day for the next 6 months to slow down the patient's Osteoporosis progression."

- Your provider must state a specific length of treatment. Lifetime or indefinite lengths of treatment will not be approved.

Current Date

Provider Name
Address
City, State Zip

Re: *Patient Name*

To Whom It May Concern:

I am writing on behalf of my patient, *(patient name)* to document the medical necessity of *(treatment/medication/equipment – item in question)* for the treatment of *(specific diagnosis)*. This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale.

Patient's History and Diagnosis:
(Include information here regarding the patient's condition and specific diagnosis. Also include the patient's history related to their condition)

Treatment Rationale:
(Include information on the treatment up to this point, course of care and why the treatment/medication/equipment (item in question) is necessary and how you expect that it will help the patient.)

Duration:
(Length of time treatment/medication/equipment (item in question) is necessary – not to exceed 12 months)

Summary:
In summary, *(treatment/medication/equipment – item in question)* is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of *(treatment/medication/equipment – item in question).*

Sincerely,
(*Physicians name and signature*) Your licensed provider must complete, sign and date the letter.